Florida HEALTH
Putnam

Florida Breast and Cervical Cancer Early Detection Program (FBCC)

APPLICATION PACKET

Client and Website Only

For questions please call:	
Regional Coordinator:	Rita J. Cianfrocco, Regional Program Manager, Patient Navigator
Counties Served by Region:	Putnam-Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Suwannee and Union.
Phone: (386) 326-3281 or 3220	Confidential Fax: (386) 643-6677

Please use checklist below to ensure all paperwork is completed and returned with this coversheet to:

Putnam Regional FBCC Office via confidential fax or mail to:

Florida Department of Health Putnam County
Florida Breast and Cervical Cancer Early Detection Program
2801 Kennedy Street
IPalatka, FL 32177

CLIENT CHECKLIST	
☐	Annual Applicant Agreement
☐	Financial Eligibility Form
☐	Client Enrollment Form
☐	Initiation of Services *(for County Health Departments only)*
☐	Authorization to Disclose Confidential Information
☐	Your Provider's Mammogram Order

Florida Breast and Cervical Cancer Early Detection Program

Annual Applicant Agreement

The Annual Applicant Agreement (AAA) is used to obtain authorization and information from eligible women enrolled in the Florida Breast and Cervical Cancer Early Detection Program (FBCC). The FBCC will collect participant Protected Health Information (PHI) and Personally Identifiable Information (PII) that is required to provide patient services.

Please read each statement below and agree by signing at the bottom of the document.

As an FBCC applicant, I declare that:

1. I am a Florida resident and I want to become a client of the FBCC, and I may withdraw at any time.
2. My net family annual income is at or below 200% of the Federal Poverty Level (FPL) and I have no health insurance that pays for breast and cervical cancer screening exams.
3. I will no longer be eligible for FBCC if my income changes to above 200% of the FPL.
4. I will call FBCC Once I obtain health insurance and give them the name of the health insurance company, policy number and effective date. If my health insurance covers breast and cervical cancer screenings my screenings will no longer be paid for by FBCC.
5. I will disclose any breast or cervical screening services that may impact my eligibility of enrollment in FBCC.
6. I may have a share of cost for some services.
7. I will use an authorized provider for my breast and/or cervical screening examinations (breast exam, mammogram, and/or Pap test).
8. **I agree to complete any follow-up tests within 60 days. If I fail to meet these guidelines, I may be responsible for partial or full cost of all services.**
9. I will allow an exchange and release of my medical information between my health care providers, the FBCC, the Florida Department of Health's Cancer Data Registry, the Centers for Disease Control and Prevention, and others related to my health care. This information could include medical history, examination and procedure results, even if they were not paid by FBCC.
10. I agree to receive home phone, cellphone, email or postal mail contact from FBCC and the Department of Children and Families (DCF) Medicaid Program about my health care.
11. I understand that the FBCC is a breast and cervical cancer **screening** program, not a cancer treatment program.
12. If I am diagnosed with breast or cervical cancer as a result of FBCC screening, I will be referred to DCF Medicaid Program which will determine if I am eligible for Medicaid benefits to cover treatment cost. I can reapply to FBCC for screenings once treatment is completed.
13. This agreement is for **one** year unless my program eligibility changes. If my eligibility status changes or this agreement expires, I may be responsible for services provided during my FBCC ineligible period.
14. **As authorized by federal law, Title 5 U.S. Code section 552a, collection of social security numbers by the Florida Department of Health for the FBCC may be necessary in order to apply for and receive Medicaid benefits.**

If you have any questions, contact your Regional Coordinator at the local Regional FBCC office:

Local Regional FBCC: Putnam County Phone 386-326-3281 or 3220

Client Signature _____ Date _____

Printed Name _____ Date of Birth _____

Client Email Address: _____

Florida Breast and Cervical Cancer Early Detection Program (FBCCEDP)

FINANCIAL ELIGIBILITY

Client Name:_____ **Date of Birth:**_____ **ID#**_____

1. Do you have Medicaid? ☐ YES ☐ NO **OR** Do you have Medicare? ☐ YES ☐ NO
2. Do you have any form of health insurance? ☐ YES ☐ NO Name of insurance _____
3. **Number of people in your Household.**_____(include yourself, spouse or civil union partner, and dependent children)
4. **Net Household Income (After Taxes): $**_____Month **OR $**_____Year

Family Size	2023 DOH Scale Monthly Income	2023 DOH Scale Yearly Income
1	$2,429.91	$29,159.00
2	$3,286.58	$39,439.00
3	$4,143.25	$49,719.00
4	$4,999.91	$59,999.00
5	$5,856.58	$70,279.00
6	$6,713.25	$80,559.00
7	$7,569.91	$90,839.00
8	$8,426.58	$101,119.00
9	$9,283.25	$111,399.00
10	$10,139.91	$121,679.00

I certify that the above information is correct to the best of my knowledge and belief. I give my consent to the Department of Health to make inquiry and verify the information. I understand that I may be prosecuted under state law, if I have deliberately supplied the wrong information.

NOTE:

If I obtain health insurance coverage, while under the FBCCEDP, it is my responsibility to notify the REGIONAL FBCCEDP office as soon as possible.

Signature_____

Date _____

If you have any questions, please call the regional coordinator at (386)326-3281 or (386)326-3220 Message between 8:00 a.m. and 5:00 p.m., Monday through Friday. We will make every effort to return your call in a timely manner.

I further understand that all my screening and diagnostic procedures must be completed within 60 days or payment for these services CANNOT be guaranteed.

Florida HEALTH
Putnam

Florida Breast and Cervical Cancer Early Detection Program

Client Enrollment Form

LAST NAME:		FIRST NAME:		MAIDEN NAME:		DATE OF BIRTH:	

1. APPLICANT INFORMATION (Please complete each section of this application.)

CONTACT INFORMATION

STREET ADDRESS:	
STREET ADDRESS:	
CITY & ZIP CODE:	
EMAIL ADDRESS:	
PRIMARY PHONE:	
ALTERNATE PHONE:	

BEST TIME TO REACH YOU:

☐ A.M. ☐ P.M. ☐ Anytime

☐ Is it okay to leave a message?

PREFERRED APPT. DAY/TIME:

HOW DID YOU HEAR ABOUT THIS PROGRAM? (Check all that apply.)

☐ American Cancer Society
☐ Brochure
☐ County Health Department
☐ Community/Health Fair event
☐ Family/Friend
☐ Internet/Website
☐ Private Medical Office
☐ Newspaper
☐ Federally Qualified Health Center
☐ Other
☐ Postcard
☐ Television
☐ Radio
☐ Social Media
☐ Educational Session
☐ Bus wraps/benches/signs
☐ Billboards

Name of Community Health Clinic: _____

Resident's County: _____

SCREENING STATUS (Check only one response.)

☐ Initial (first time in program) ☐ Rescreen (previously in program)

☐ Short-term interval follow-up or repeat exam (less than 300 days from last screening)

Do you have health insurance? ☐ Yes ☐ No

If yes, what is the name of your insurance? _____

DEMOGRAPHIC INFORMATION

RESIDENTIAL AND CITIZENSHIP STATUS (Check all that apply.)

☐ Florida resident ☐ U.S. Citizen ☐ Citizen in lawful status ☐ Other

ETHNICITY AND RACE IDENTIFICATION (Check all that apply.)

☐ Hispanic/Latino ☐ Non-Hispanic/Latino

RACIAL IDENTITY

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

SPOKEN LANGUAGE(S)

Primary language spoken: _____

Additional language(s) spoken: _____

Language preference to receive email:

☐ English ☐ Spanish ☐ Haitian Creole

BARRIERS

Are there any barriers that would prevent you from keeping your appointments?

☐ Transportation ☐ Language ☐ Disabilities

☐ Other (List) _____

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#: _____

Florida HEALTH
Putnam

Florida Breast and Cervical Cancer Early Detection Program

Client Enrollment Form

LAST NAME:		FIRST NAME:		MAIDEN NAME:		DATE OF BIRTH:	

2. HEALTH HISTORY

GENERAL HEALTH STATUS (Check all that apply)

- ☐ Diabetes
- ☐ Pre-Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol

HEIGHT (in.): ☐ WEIGHT (lbs.): ☐

TOBACCO USE (includes vaping, e-cigarettes, and similar products) (Check all that apply)

- ☐ Daily
- ☐ Some days
- ☐ Never/not at all
- ☐ Declined to answer
- ☐ Were you given a referral to Quitline?
- ☐ Declined referral
- ☐ I am interested in quitting.

BREAST EXAM BACKGROUND (Check all that apply)

- ☐ Do you have breast implants?
- ☐ Are you currently experiencing any issues with your breasts? Explain.

☐ Have you ever been diagnosed with breast cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last mammogram before enrolling in this program? (Month/Year)

☐ ☐ None ☐ Unsured (2+ years)

Where was your last mammogram done? (Provider, City, State)

CERVICAL EXAM BACKGROUND (Check all that apply)

☐ Are you currently experiencing any issues with your cervix? Explain.

☐ Have you ever been told by a doctor you have invasive cervical cancer?

If you have, what treatment did you receive?

When did your treatment end (Month/Year)?

When was your last Pap test before enrolling in this program? (Month/Year)

☐ ☐ None ☐ Unsured (10+ years)

Where was your last Pap test done? (Provider, City, State)

☐ Have you ever had a hysterectomy? Specify whether partial or full.

☐ Partial hysterectomy (I still have a cervix) ☐ Full hysterectomy (no cervix)

What was the reason for the hysterectomy?

FAMILY HISTORY

Has anyone in your family, such as your mother, sister, brother, or father, been diagnosed with breast cancer? If yes, which relative?

FOR OFFICE USE ONLY

Client Assigned ID# or Pseudo SS#:

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: Rita J. Cianfrocco, BCC Regional Program Manager **Phone #:** 386-326-3281

METHOD OF DISCLOSURE:

_____ **Pick up at Clinic/Facility**

_____ **Address:** DOH-Putnam County, 2801 Kennedy Street, Palatka, FL 32177

_____ **Fax #:** 386-643-6677 Secure Fax

_____ **Email Address: (please note that emailing may not be a secured method of communication)**
Rita.Cianfrocco@flhealth.gov | Do Not Email Sensitive Information.

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s) _____ STD Records _____ TB Records _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Progress Notes

_____ Diagnostic Test Reports (Specify Type of test(s) All breast and cervical screenings, diagnostics, imaging and labs.

_____ Other: (specify) FBCCEDP/CDC/Florida Department of Health in Putnam County and Central Office, Tallahassee, FL (Consent to Contact by phone or email).

I specifically authorize release of information relating to: (initial selection)

_____ HIV test results _____ Substance Abuse Service Provider Client Records

_____ Psychiatric, Psychological or Psychotherapeutic notes _____ Early Intervention _____ WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify Provider Reimbursement and Management by FBCCED Program

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____
Client/Legal Representative Signature Date

_____ _____
Printed Name Legal Representative's Relationship to Client

If you are a legal representative of the person whose information you are requesting, you must provide documentation proving your legal authority to the request this information (for example, power of attorney, healthcare surrogate form, order, appointment of a guardianship, order appointing personal representative, letters of administration).

Client Name: _____

ID#: _____

DOB: _____

DH3203-SSG-09/2017

Original: To File **Copy:** To Client **Copy:** To Accompany Disclosure

Health Care Provider Referral Form to Tobacco Free Florida

Tobacco Free Florida's Provider Referral Form Use Instructions

I. Provider Information (Required) *Provider fills out. Select Hospital or Non-Hospital. See examples on back.*

☐ **HOSPITAL** ☒ **NON-HOSPITAL**

Health System: _____ Umbrella Organization: FDOH – Putnam County

Hospital Name: _____ Clinic/Agency: FBCCEDP

Department: _____ Dept/Location: Palatka, FL

Provider Name: Provider Name:

Main Contact Person: Rita J. Cianfrocco Email: Rita.Cianfrocco@flhealth.gov

Phone: (386) 326-3281 or 3278 Fax: (386) 643-6677

Address: 2801 KENNEDY STREET City: PALATKA State: FL Zip Code: 32177

I am a HIPAA Covered Entity and I want a feedback report: ☒ Yes ☐ No

II. Patient Information (Required) *Patient fills out*

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Email: _____

Best Phone Number: _____ Alternate Phone Number: _____

The best time to call you: *(check one)*

☐ Morning: 8am – Noon ☐ Afternoon: Noon – 5pm ☐ Evening: 5 – 9pm ☐ Anytime

Can we leave a voicemail? *(check one)*

☐ Yes ☐ No

My signature gives permission for my provider to send this form to a Tobacco Free Florida representative. I understand that I will be contacted within the next week.

Patient Signature: _____ Date: _____

Program Choice: *Check **ONE** box below (see program descriptions on back). The provider will then submit this form via fax or email to the program listed below.*

☐ Attend an in-person group or virtual class ***Fax:*** *1-888-975-1534* | ***Email:*** *tobacco@ahec.ufl.edu*

☐ Talk to a Quit Coach® over the phone ***Fax:*** *1-866-688-7577* | ***Email:*** *supportservices@optum.com*

Health Care Provider Referral Form to Tobacco Free Florida

Tobacco Free Florida's Provider Referral Form Use Instructions

Referral Form Submission Instructions

I. Provider Information: The provider completes this section. Examples are listed below:

Hospitals	**Example 1**	**Example 2**	**Example 3**
Health System:	UF Health	Memorial Healthcare System	Flagler Health
Hospital Name:	Shands Hospital	Memorial Hospital Pembroke	Flagler Hospital
Department:	Internal Medicine	Respiratory Therapy	Cardiopulmonary
Provider Name:	John Doe		Jane Smith
Non-hospitals	**Example 1**	**Example 2**	**Example 3**
Umbrella Organization:	Walgreens		
Clinic/Agency:	Walgreens	Santa Rosa County Health	Juan Pérez, D.O.
Dept/Location:	#1234		
Provider Name:	John Doe	Jane Doe	Juan Pérez, D.O.

II. Patient Information: The patient provides their contact information.

***Program Choice*:** Patient should select ONE program from the list.

- Provider should fax or email completed forms to the program the patient has selected.
- If the referral is sent to the in-person group or virtual class, the patient will be called by the Florida Area Health Education Center (AHEC) that serves the patient's county to schedule them in a course.
- If the referral is sent to the telephone program, a tobacco Quit Coach will call the patient to enroll them in their preferred program.

Tobacco Free Florida Program Options

Group (Virtual) Quit

Register for a session with trained facilitators along with others who want to quit like you.

- Led by a trained specialist
- 2 to 4 weeks nicotine patches, gum or lozenges
- Convenient times & locations
- Group support

Phone Quit

A Quit Coach® is waiting for your call to help you on your journey to be tobacco free.

- Quit Coach® 24/7
- 2 weeks nicotine patches or gum
- Custom plan
- 3 calls from Quit Coach®
- 1-877-U-CAN-NOW (1-877-822-6669)

Need more information about the programs available? Visit: https://tobaccofreeflorida.com/how-to-quit-tobacco/smoking-cessation-programs